DEKALB COUNTY SCHOOL DISTRICT EMPLOYEE ACCIDENT REPORT

FOR ALL ACCIDENT INVOLVING EMPLOYEES ONLY

ALL SECTIONS MUST BE COMPLETED WITH AS MUCH INFORMATION AVAILABLE

** ACCIDENT FORMS MUST BE COMPLETED BY DESIGNEATED DEPT. PERSONNEL **

***SUBMIT TO WORKERS' COMPENSATION DEPARTMENT AS SOON AS POSSIBLE ***

Employee's Full Name: _____ **Date of Birth:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **SS#:** _____ **Sex:** _____

Daytime Phone: _____ **Date Reported to Supervisor:** _____

Date of Injury: _____ **Time of Injury:** _____ **Supervisor's Initials:** _____

Time workday began: _____ **Number of Hours Normally Worked per Week:** _____

School/Dept.: _____ **School/ Dept. Number:** _____

Position/ Title: _____ **Print Supervisor's Full Name:** _____

Nature of Injury/ Illness: _____ **Part of Body:** _____

Please specify: Strain, Laceration, Bruise, Burn, Fracture, etc. Back, Finger, Hand, Foot, Leg, etc. Left/Right? Upper/Lower?, etc.

Initial Treatment Status:

No Treatment Needed* _____ Minor/Physician or Clinic_____Hospital_____

All employees should be given an Authorization to Physician Form to complete whether treatment is needed or not.

If Applicable: Treating Physician's Name:_____Hospital:_____

Location of Injury/ Illness: On Premises_____ Off Premises_____Approved Route _____

Place: _____ **Address:** _____

Classroom, Cafeteria, Playground, School Parking Lot, etc.

HOW did injury or illness/abnormal health condition occur? Please be specific and clear.

_____

_____

_____

You may elect to use sick days in lieu of receiving Workers' Compensation benefits. You have_____sick days available.

I Do_____Do Not_____elect to use my sick days.

IF UNABLE TO WORK, EMPLOYEE MUST IMMEDIATELY NOTIFY: WORKERS' COMPENSATION CLAIM DEPARTMENT AT WORKERSCOMPENSATION@DEKALBSCHOOLSGA.ORG

Employee Signature: _____ **Date:** _____

Print Name Here: _____

****Witness Signature** _____ **Date:** _____

Print Name Here: _____

*****Person who actually saw/heard/knew of accident*

Work Location: _____ Work Phone #: _____

Home Address: _____ Home Phone #: _____

Supervisor Signature: _____ **Date:** _____

Print Name Here: _____ Phone: _____

Principal/ Director Signature: _____ **Date:** _____

Print Name Here: _____ Phone: _____

*** Please email this signed and completed form to workerscompensation@dekalbschoolsga.org***